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Conference Abstract

Enhancing integrated working and care coordination at the transitional points between custody and community mental health teams

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Abstract:

Overall Purpose: To investigate the referral processes in use by mental health staff working in the custodial environments of police stations and remand prisons and referring service users with mental illness to community mental health teams for aftercare.

Objectives: To examine current referral processes for continued care using 'process mapping'; To establish good practice, service barriers and tensions that affect the seamless provision of care from custody to community living; To highlight areas of inefficiency such as delays, duplication and potential errors within the referral system; To improve the effectiveness and co-ordination of care for service users at the point of transfer of care; To make recommendations for improving the care pathway for service users involved at the 'entry' points of the criminal justice system (arrest and remand).

Background: The recent Bradley Report [1]highlighted the need for improved partnerships between health and criminal justice agencies to identify and manage offenders with mental health needs more proactively and productively both in prison and the community. Bradley proposed the wider availability of Criminal Justice Mental Health teams to divert people towards support services from police stations, courts and following release from prison. However, many of Lord Bradley's recommendations are yet to be initiated.

There are high prevalence rates for mental illness throughout the criminal justice system (CJS) and inconsistent identification within the community, police stations, courts and prisons. People who occupy various stages of the CJS and have mental illness are often considered ‘complex’, ‘high risk’ and ‘difficult to engage’[1,2]. Despite the improvements in prison health care there continues to be a lack of appropriate follow up at the gate, where people are at their most vulnerable to relapse, reoffending and disengagement. Given that the multiple and complex nature of service users’ health and social needs the provision of an integrated and seamless package of care at the point of release is essential.

Conclusions: Anecdotally, non-attendance and disengagement is high among offenders referred to both primary and community mental health teams. A process mapping exercise was conducted within a police custody suite which revealed for example the establishment of an ‘opt in’ system for accessing primary care mental health services, which can be difficult for service users who have insecure or changeable home addresses.

Barriers exist in accessing community mental health teams as they do not always accept referrals for people with dual or multiple diagnosis or deemed high risk. They also operate 'three strikes and you are out' procedures in that if the service user fails to respond to three attempted contacts by phone or letter they are discharged, irrespective of this potentially being a sign of relapse. New national directives and local arrangements to improve the procedures for referral and transitional care are needed to ensure safe and effective transfer from custodial to community based mental health care.

Keywords

transitional care, mental health, custody, process mapping, multi-disciplinary work, England

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